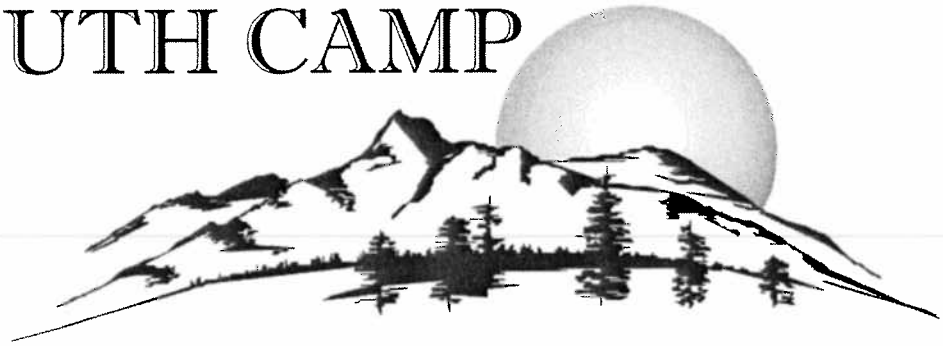
CHINA SPRING YOUTH CAMP



AURORA PINES

Admission Packet

THIS SECTION TO BE PROVIDED TO

PARENTS/LEGAL GUARDIANS

UPDATED **February 2011**

CHINA SPRING
YOUTH CAMP

AURORA PINES
GIRLS FACILITY

225 CHINA SPRING RD.
GARDNERVILLE, NV 89410
P.O. BOX 218
MINDEN, NV 89423

"Serving Youth Since 1980"

WENDY GARRISON, DIRECTOR YOUTH SERVICES

JEFF GORTON, FACILITY MANAGER
HEATHER FIELD, FACILITY MANAGER

(775) 265-5350 CSYC MAIN
(775) 265-5811 APGF MAIN

(775) 265-7159 CSYC FAX

We have been informed your child was committed to China Spring Youth Camp/Aurora Pines Girls Facility. In an effort to facilitate the intake process, we are requesting the following documents be completed and given to your child's probation officer prior to his/her arrival.

We understand this may be the first time your child will be away from home for an extended period of time. Because of this, we understand, you may have many doubts and concerns about what we do at China Spring/Aurora Pines. Before asking you some detailed information about your child, let us take a minute to explain what the China Spring/Aurora Pines program is about and what you and your child can expect.

China Spring/Aurora Pines is dedicated to helping mid-level offenders between the ages of 12 and 18 develop skills, knowledge and experience to promote health and resiliency, stop the progression of problems caused by delinquent behavior and interpret and avoid high risk behavior patterns in an emotionally safe, comforting, challenging and nurturing environment.

We have no bars on the windows or locks on the doors. We do have alarms and security policies, but our philosophy is one of honor, trust and accountability. We are dedicated to helping your child define themself and their values while providing the least restrictive environment. We provide structure and programs to help your child become a productive member of your family and community.

The staff is available to assist you and your child in a variety of capacities. The Case Manager is the person who is responsible for your child's coordination of treatment and your child will be assigned a Case Manager upon arrival. The Case Manager is the staff with whom you will have the most contact. The Case Manager and staff have a real concern for the welfare of your child, but under no circumstances will they accept inappropriate behavior. Their job is to teach your child to become a more responsible person. They will expect your child to act responsibly and will not accept excuses for irresponsible behavior.

The following is a list of services and programing provided by the camp:

- Medical Services
  Your child will receive medical and dental care deemed to be in his/her best interest and directed by our facility nurse and/or doctor. In all cases we/doctor will bill you for the service of the doctor or medication prescribed. If, at any time, your child feels ill, s/he has the ability to notify a staff member. They will immediately help your child with minor problems and initiate a referral to the facility nurse. The facility nurse handles minor medical requests twice weekly. In the event your child needs more serious attention, we will refer him/her to the facility's doctor. In all cases, where a referral is made to a medical doctor, you will be notified and will be asked to provide transportation to a medical doctor of your choosing. If it is an emergency, or you are not physically able to transport your child to a physician of your choosing, the facility may provide transportation. It is for this reason the attached medical information sheet must be filled out in its entirety. Please be advised Medicaid does not cover for any medical expenses after your child has been here for 30 days. Any medical bills accrued after this time will be your responsibility to pay in full.

- Educational Program
  Your child will be required to participate in an educational program as part of his/her individual treatment plan. The educational program is operated by the Douglas County School District through Jacobsen High School. Credits your child earns will be transferable to the school s/he attends after leaving the facility. Educational goals will be developed by the Jacobsen High School staff with input from your child's Case Manager. Your child will be taking a placement test upon her arrival into the facility. This test along with a review of your child's past school history, the completion

of a personal interview with your child, your input, and your child's input will be used to formulate the most appropriate educational plan.

School begins at 7:30 a.m. and ends at 11:40 a.m. for the lunch break. Classes resume at 1:30 p.m. and end at 2:30 p.m.

- Wilderness Program
  Your child may be involved with the wilderness program. The Wilderness Program includes activities such as hiking, camping, fishing, rafting, trail construction, snow shoeing, and cross country skiing.

- Youth Development System
  The basic program of the facility is called the Youth Development System is based upon psycho-social principles of adolescent growth. Unlike behavior modification and token economy systems which rely on rewards and punishments to modify behavior, the Youth Development System is designed to help your child learn, grow, and experience progress. As such, the Youth Development System is directed at achieving positive changes in your child's attitudes, values, thinking processes, as well as behavior.

  The China Spring Youth Camp/Aurora Pines Girls Facility utilizes a system for tracking your child's progress throughout the program. The Youth Development System divides the Program into four stages. The stages are designed to provide structure, guidance, support and feedback concerning your child's behavior and progress in the program. It is designed to grant increased responsibilities and privileges, maintain motivation and increase self-esteem as your child progresses through the program and toward his/her eventual return to the community.

Orientation Stage
This stage is also known as the "Reluctant Beginner." It is expected that your child will remain in Orientation Stage approximately 21 to 45 days. This stage is to help your child adjust to the routine of the program policies and procedures, get acquainted with staff and residents, and feel like s/he is part of the China Spring Youth Camp/Aurora Pines Girls Facility. Upon completion of the Orientation Stage your child will know the program expectations well enough to function independently and be motivated to attain higher levels of program responsibility.

It is important to note while your child is in Orientation Stage you will not have any phone contact or visits until s/he is either promoted to Adjustment Stage or has been here for 30 days. However, your child is encouraged to write letters to family and is able to receive letters as early as his/her first day in the facility.

Adjustment Stage
Residents in this stage are referred to as "Enthusiastic Learners". Your child will spend the most time at this stage. The majority of the individualized programs and contracts will be developed and accomplished as your child works toward more responsibilities, privileges, and advancement to the next stage. Your child will also receive a Treatment Plan, authored by the Case Manager, which will address past behavioral and cognitive issues.

It is expected your child will do well at times and have problems at other times. It is from this problem identification your child will become aware of the patterns of behavior and communication which may have contributed to his/ her commitment. Your child will develop and attain goals to solve and approach problem situations. At all times your child is expected to be accountable for his/her choices and actions.

Transition Stage
Residents in this stage act as "Cautious Performers." When your child is performing independently, progressing toward achieving person goals, demonstrating responsible and consistent behavior, is motivated and is a positive influence, s/he will then be granted Transition Stage status.

Transition Stage is designed to give your child more responsibility and a chance to demonstrate his/her ability to successfully function at the facility and in the community. Your child will continue to work on contracts, and identifying areas which have caused conflict in your child's life. Special emphasis will be placed on family interactions. In Transition Stage, your child will begin the reintegration back into your home. Your child will be allowed to return home every other weekend and have only limited phone contact with friends.

Honor Stage
The Honor Stage is designed to help your child separate from the facility. Your child will, therefore, spend his/her time focusing on her return to family and community and leaving the group. During this stage, your child will be expected to act as a "Competent and Committed Performer". Your child will also be eligible to return home every weekend and have limited contact with friends.

- Contraband
  Your child may not be in possession of any item not specifically listed on the required belongings list in this packet. We understand there may be times when you want to bring or send your child "treats" or gifts, but your child will not be allowed to receive these. Administration or counselors will give you special instructions to follow during the holidays. Exceptions are not made for birthdays or other occasions. Your child may not carry or have in her possession any money, food, gum, or any item not approved by the facility's administration.

- Visiting
  During your child's stay, you will have an active role in your child's treatment program. As such, visitation privileges are offered in a fashion consistent with your child's behavior and progress in his/her treatment plan. In-facility family visits will be limited to parents, grandparents, and/or legal guardians only. Visiting is always Sundays from 9:00 a.m.-11:00 a.m. for Aurora Pines Girls Facility and China Spring Youth Camp. You may return to participate in church services with your child on Sundays from 1:00 p.m.-3:00 p.m. for Aurora Pines Girls Facility and 1:30 p.m.-3:30 p.m. for China Spring Youth Camp.

  Exceptions to the visiting guidelines are rarely granted and are to be requested to the Case Manager. Your child may receive an incoming phone call, if s/he was unable to receive an in facility visit. You may call Monday through Friday between the 8:00 a.m. and 8:00 p.m. Please consult the daily schedule in this letter for an idea of the best times to phone your child. Due to resource demands, your child's phone call will be limited to ten minutes. As with in-facility visits your child may only speak to parents, grandparents, and/or legal guardians. Incoming phone calls will not be allowed during school hours. Outgoing phone calls are not made for weekly contacts unless there are extreme circumstances.

- Parent Awareness Classes
  Your child will get assistance in addressing many issues during his/her placement in the facility; one of these issues will be your child's reintegration into the family. It is our sincere desire to make this transition as smooth as possible. One of the steps we have taken to assist you with your child's return home is to provide Parent Awareness classes. The class will be facilitated by Mrs. Kelly Bielat, MFT. This process will focus on the changes your child is expected to make and how these changes may affect your family. Because it is important to the resident's success, we recommend you make arrangements to attend at least three classes. One class must be attended prior to your child's first weekend home visit. The classes are held every Friday from 12:30 p.m.-1:30 p.m. in the visiting area of the girl's dormitory for Aurora Pines Girls Facility and 1:30 p.m.-2:30 p.m. in the lobby of the boy's dormitory for China Spring Youth Camp.

- Mail
  Your child will be allowed to correspond with parents/guardians, family members, lawyers, and Probation Officer. The suggested list is not inclusive and may consist of individuals who have a direct positive influence upon your child.

If you have questions or concerns, please do not hesitate to contact the facility. Your questions/concerns will be directed to those best able to address the issue.

Sincerely,

Wendy C. Garrison, Director

(Please keep this letter for your reference)

DAILY SCHEDULE

The following is an example of the schedule your child will follow on any given day:

Wake Up	5:30 a.m.
Breakfast	6:00 a.m. to 6:30 a.m.
Clean Up (Dorm & Kitchen)/Group Counseling	6:30 a.m. to 7:15 a.m.
School Begins	7:30 a.m. to 11:40 a.m.
Lunch/Chores	12:00 p.m. to 1:30 p.m.
School Resumes	1:30 p.m. to 2:30 p.m.
Counseling/Work Detail/Treatment Issues/Reflection Time	2:30 p.m. to 5:00 p.m.
Dinner	5:00 p.m. to 6:00 p.m.
Study Hour/Counseling	6:00 p.m. to 7:00 p.m.
Showers/Chores	7:00 p.m. to 8:00 p.m.
Letter Writing/Group & Individual Counseling	8:00 p.m. to 9:00 p.m.
Lights Out	9:00 p.m.

VISITING RULES

Please remember this is a controlled environment and the rules are necessary for a safe, secure facility.

1. Photo ID is required upon arrival.
2. Sunday visits are from 9:00 a.m. to 11:00 a.m. for both facilities.
3. Church services on Sundays are from 1:00 p.m. to 3:00 p.m. For Aurora Pines Girls Facility and 1:30 p.m. to 3:30 p.m.
4. Parents/Grandparents/Guardians, ONLY, are allowed to visit and/or attend Church.
5. Any visitor under the influence of an intoxicant will not be allowed on Facility property. Local law enforcement will be notified.
6. All visitors and vehicles are subject to search.
7. No unauthorized visitors are allowed on facility grounds.
8. Visitors must park in the designated parking area.
9. All visitors will report to the dormitory
10. Visitors may not give anything directly to a resident. If you have something for a resident, it must be given to staff immediately upon arrival.
11. Visitors may not bring food or beverages from outside the facility.
12. No Cell Phones.
13. China Spring/Aurora Pines is a NO SMOKING facility pursuant to N.R.S. 202.2491.

PERSONAL BELONGINGS LIST

Send only what is listed. All other items will be refused.

It is advisable to leave tags on all new items and to save receipts in case items are refused.
Please pack items in a disposable box or bag. No suitcases or duffle bags permitted. Storage space in camp is limited.

All clothing items must be:

1 Sized to fit your child, baggy clothing will not be accepted, Clothing must be logo free
2 Expensive items are discouraged and may be refused

All Hygiene/Health products are to be:

1 In plastic containers , Non-aerosol, Non-alcoholic
2 Perfume scents and expensive items are discouraged and may be refused
3 Labels are to be intact (medications without prescriptions labels will be refused)
4 No over the counter medications will be accepted without doctor's order

CSYC & APGF Hygiene/Health Items:

☐	Deodorant	2
☐	Shampoo	2
☐	Conditioner	2
☐	Toothpaste	2
☐	Toothbrush (holder okay)	1
☐	Dental Floss	1
☐	Sunblock (at least 30 SPF)	1
☐	Bar Soap (holder okay)	2
☐	Lip Balm	2
☐	Lotion (unscented)	2
☐	Athlete's Foot Products	2
☐	Kleenex	2
☐	Towel (solid color)	2
☐	Wash Cloth (solid)	2
☐	Comb/Brush	1
☐	Feminine Napkins/Tampon	3
☐	Hair ties (non-metal, APGF only)	3
☐	Acne Product(s)	Discretionary
☐	Medications	30 day supply

CSYC & APGF Writing Materials/Misc:

☐	Pen (blue/black)	3
☐	Pencil (not mechanical)	3
☐	High Lighter	1
☐	Binder	5
☐	Bible	1
☐	Family Picture	1
☐	Stamps	no limit
☐	Envelopes	2 boxes
☐	Paper (no spirals)	3 packs
☐	Large Duffle bag	1

CSYC & APGF Foot wear

☐	Slippers	1
☐	Work Boots	1
☐	Work Gloves	1
☐	Running Shoes (White w/ white laces)	1
☐	Shower Shoes (non-slip)	1

CSYC (Male Specific) Items:

☐	Dress Shirts (Collared)	2
☐	Sweat Pants (black or grey)	2
☐	Sweat Shirts (black or grey) (no hood)	2
☐	Shorts (black or grey) mid-thigh	2
☐	Athletic Socks (white)	12
☐	Underwear (white - standard)	12
☐	T-shirts (white) crew neck	7
☐	Pajamas (shirt with pants - modest)	2
☐	Bath Robe (modest) (cotton/terry)	1
☐	Winter Coat (season specific)	1
☐	Beanie (black/grey) (season specific)	1
☐	Baseball Style Cap (black/grey)	1
☐	Web Belt (no gang or drug symbols)	1
☐	Jeans (Blue solid)	5

APGF (Female Specific) Items:

☐	Sweat Shirt (maroon/grey) (no hood)	2
☐	Sweat Pants (maroon/grey)	2
☐	Shorts (tan) mid-thigh	2
☐	Athletic Socks (white)	12
☐	Underwear (white - standard)	12
☐	T-shirts (white) crew neck	7
☐	Bra (white - no wires)	2
☐	Sports Bra (white or grey)	2
☐	Winter Coat (season specific)	1
☐	Beanie (black/grey) (season specific)	1
☐	Baseball Style Cap (black/grey)	1
☐	Pajamas (shirt with pants - modest)	2
☐	Bath Robe (modest) (cotton/terry)	1
☐	Bathing suit (one piece- modest) (bathing suit is needed year round)	1
☐	Stuffed Animal (not large)	1

If you have any questions about this list, please call administration.

(Please keep this list for your reference)

NOTICE OF PRIVACY PRACTICES OF DOUGLAS COUNTY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

You are receiving this notice in accordance with the Health Information Portability and Accountability Act (HIPAA), a federal law which governs the privacy of your health information.

WHO WILL FOLLOW THIS NOTICE
This notice describes the information privacy practices followed by Douglas County.

YOUR HEALTH INFORMATION
This notice applies to the information and records we have about your health, health status, and the health care and services you may receive from Social Service.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose information about you and describes your rights and our obligations regarding the use and disclose of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

- **For Treatment**
  Although the County may not provide direct treatment to you, which your physicians or dentists and their staff do, we are including these next three paragraphs for your general information on the functioning of HIPAA. They may use health information about you to provide you with medical treatment or services. They may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

  For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems which could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

  Different personnel in their offices may share information about you and disclose information to people who do not work in the office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you which we have.

- **For Payment**
  We may use and disclose health information about you so the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

- **For Health Care Operations**
  We may use and disclose health information about you in order to run the office and make sure you and our other clients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our residents to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

- **Appointment Reminders**
  We may contact you as a reminder you have an appointment for treatment or medical care at the office.

- **Treatment Alternatives**
  We may tell you about or recommend possible treatment options or alternatives which may be of interest to you.

- **Health-Related Products and Services**
  We may tell you about health-related products or services which may be of interest to you.

  Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) do not wish to receive such communications, we will not use or disclose your information for these purposes.

  You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time.

  If you do not revoke your Consent, we will not be permitted to use or disclose information for purposes of treatment, payment, or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety**
  We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Required by Law**
  We will disclose health information about you when required to do so by federal, state or local law.

- **Research**
  We may use and disclose health information about you for research projects which are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address, or other information which reveals who you are, or will be involved in your care at the office.

- **Organ and Tissue Donation**
  If you are an organ donor, we may release health information to organizations which handle organ procurement or organ, eye, or tissue transplantation or to an organ donating bank, as necessary to facilitate such donation and transplantation.

- **Military, Veterans, National Security and Intelligence**
  If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other governmental authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation**
  We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks**
  We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

- **Health Oversight Activities**
  We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes**

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

- **Law Enforcement**
  We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

- **Coroners, Medical Examiners and Funeral Directors**
  We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

- **Information Not Personally Identifiable**
  We may use or disclose health information about you in a way which does not personally identify you or reveal who you are.

- **Family and Friends**
  We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

  In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences which are in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OR HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent we may have obtained from you. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the Authorization and Consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed consent and a special written Authorization which complies with the law governing HIV or substance abuse records.

YOUR RIGHT'S REGARDING HEALTH INFORMATION

You have the following rights regarding your health information we maintain:

- **Right to Inspect and Copy**
  You have the right to inspect and copy your health information, such as medical and billing records, which we use to make decisions about your care. You must submit a written request in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Amend**
  If you believe health information we have about you is incorrect or incomplete, you may ask us to amend this information. You have the right to request an amendment as long as the information is kept by this office.

  To request an amendment, complete and submit a Medical Record Amendment/Correction Form. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information which:

  1. We did not create, unless the person or entity which created the information is no longer available to make the amendment.
  2. Is no part of the health information we keep.
  3. You would not be permitted to inspect and copy.
  4. Is accurate and complete.

- **Right to an Accounting of Disclosures**
  You have the right to request an accounting of disclosures. This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must: Submit your request in writing. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions**
  You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask we not use or disclose information about a surgery you had.

- **We are Not Required to Agree to Your Request**
  If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions, you may complete and submit the "Request for Restriction on Use/Disclose of Medical Information".

- **Right to Request Confidential Communication**
  You have the right to request we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask we only contact you at work or by mail.

  To request confidential communications, you may complete and submit the Request

- **For Restriction on Use/Disclosure of Medical Information and/or Confidential Communication**
  We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice**
  You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact Wendy Garrison.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of this notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Wendy Garrison. You will not be penalized for filing a complaint.

Attention Parent: Pages 1-9 of this packet are yours to keep. The following pages need to be reviewed, signed and submitted to the Juvenile Probation Office to be provided to Camp at the time of intake.

This Section Contains Forms to be Completed by Parent/Guardian and Submitted to Camp at time of Intake.

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize Douglas County to use and disclose my medical for the purposes of Treatment, Payment and Health Care Operations.

Treatment includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by a physician who covers my/our practice by telephone as the on-call physician.

Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

Health Care Operations includes the necessary administrative and business functions of our office.

You have the right to revoke this Authorization at any time, provided you do so in writing and except to the extent we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

You may review Douglas County's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your fist visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand I have the right to revoke this Consent provided I do so in writing, except to the extent Douglas County has already used or disclosed the information in reliance on this Consent and to examine the County's Notice of Privacy Practices.

_____ _____

Signature of Resident or Person Authorized by Law Date

HIPAA

Form A

CHINA SPRING YOUTH CAMP AURORA PINES GIRLS FACILITY
AUTHORIZATION FOR RELEASE OF INFORMATION

Child's Name: _____ Date of Birth: _____

I understand my records are protected under the Federal Confidentiality Records Act and the restrictions regarding confidentiality of juvenile records as outlined in N.R.S. Chapter 62, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand I may revoke this consent at any time except to the extent action has been taken in reliance on it, and in any event this consent expires automatically as described below.

I understand this consent authorizes either written or verbal transfer of the referenced information below. I waive on behalf of the above named child and myself all provisions of law relating to disclosure of confidential information, and release the Douglas County China Spring Youth Camp/Aurora Pines Girls facility from any liability which may arise from this authorization.

I HEREBY AUTHORIZE:

A. Any physician, hospital, institution, psychologist, social worker, school, or state, county, and federal agency having appropriate medical, psychiatric, psychological, social case, educational, vocational, and/or employment records, reports and/or evaluations pertaining to the resident named below, to disclose such records to the China Spring Youth Camp/Aurora Pines Girls Facility, so they may process this case for medical services and/or treatment services.

B. The China Spring Youth Camp/Aurora Pines Girls Facility to release any physician, hospital, institution, psychiatrist, psychologist, social worker, school or state, county and federal agency, any information pertaining to the resident named below which may be pertinent to a better understanding and more thorough evaluation of this medical service and/or treatment service.

C. The China Spring Youth Camp/Aurora Pines Girls Facility to prepare certified copies of this authorization for the purpose of obtaining information from multiple sources. Such copies are to contain the statement: "I CERTIFY THIS COPY TO BE A TRUE COPY OF THE ORIGINAL", and be certified as to a true copy by the China Spring Youth Camp/Aurora Pines Girls Facility.

It is understood by the undersigned the authorization for disclosure contained herein shall include information pertaining to services and related benefits which may have been rendered or paid under any applicable health insurance coverage or any other health or medical protection plan, and any such information in the possession of any such provider of health or medical insurance coverage pertaining to the resident below may be disclosed to the China Spring Youth Camp/Aurora Pines Girls Facility.

I understand this authorization is valid while my son/daughter is a resident at China Spring Youth Camp/Aurora Pines Girls Facility and for a period of one (1) year after the discharge of the child.

_____ _____

Resident Parent/Guardian or Primary Caretaker

State of Nevada)
)ss
County of _____,)

On _____, 20 __ before me, _____

(Notary's Name)

AUTHORIZATION FOR EMERGENCY MEDICAL/MENTAL HEALTH CARE (LIMITED POWER OF ATTORNEY)

I, _____ am the parent or
(Print Name of parent/guardian)

legal guardian of _____ ,a minor child. I reside at
(Print name of child)

_____ _____ _____ _____
(Street address) (City) (State) (Zip Code)

My telephone numbers are:

Home _____ Work _____ Cellular _____

I hereby appoint Wendy Garrison, Director, China Spring Youth Camp/Aurora Pines Girls Facility, Gardnerville, Nevada, or an agent or employee of China Spring Youth Camp/Aurora Pines Girls Facility acting on her behalf, as my true lawful attorney to act in my place to do any of the following acts with respect to **emergency medical or mental health care** for the above named child:

1. To obtain emergency medical or mental health care including admission to hospitals or other institutions.
2. To consent to, refuse to consent to, or withdraw consent to any care, test, surgery, services or procedures to maintain, diagnose or treat a physical or mental condition.
3. To sign such medical forms as may be necessary to carry out such decisions, including insurance forms, to talk to health care personnel who are treating the child and examine medical records related to the child's care.

This limited power or attorney is made subject to the condition the attorney in fact (CSYC/APGF) shall exercise best efforts to notify the parent or legal guardian as soon as possible when exercising the powers granted herein, but in any event, within 24 hours.

This limited power of attorney shall remain in full force and effect during the time the named child is a resident of China Spring Youth Camp/Aurora Pines Girls Facility.

☐ Child has no insurance

☐ Child has insurance

Dated this _____ , day of _____ 20 ____

_____
(Signature of parent/guardian)

_____
(Witness)

_____
(Probation Officer)

Form C

Please provide a legible copy of your child's insurance cards (including dental and prescription if separate) in place of this page.

(Front and back)

CHINA SPRING YOUTH CAMP/AURORA PINES GIRLS FACILITY

MEDICAL INSURANCE FORM

Primary Medical Insurance Carrier: _____

Policy Holder Name: _____

If your child is covered by another insurance carrier, please complete the following

Secondary Medical Insurance Carrier: _____

Policy Holder Name:

_____

Prescription Coverage:

Prescription Carrier _____

Policy Holder Name: _____

Dental Insurance Coverage:

Primary Insurance Carrier: _____

Policy Holder Name: _____

INSURANCE AUTHORIZATION

I _____

(Print Name)

Authorize and assign CSYC/APGF and its representatives to use my insurance for the benefit of my Son/Daughter. I also understand I am financially responsible for whatever portion insurance does not cover including but not limited to deductibles, co-payment amounts and non-covered services. In accordance with NRS 62 B.110: "When a child who is under the jurisdiction of the Juvenile Division of the District Court pursuant to this chapter, receives ancillary services administered or financed by a county including but not limited to, transportation, or psychiatric, psychological or medical services, the county is entitled to be reimbursed for such services from the parent of the child."

_____ _____

Guardian Signature Date

Form E (Insured)

UNINSURED PARENTS/GUARDIANS

I _____

(Print Name)

understand I am financially responsible for whatever medical/ancillary services are provided to my child during the course of their commitment to China Spring Youth Camp in accordance with NRS 62 B.110 "When a child who is under the jurisdiction of the Juvenile Division of the District Court pursuant to this chapter, receives ancillary services administered or financed by a county including but not limited to, transportation, or psychiatric, psychological or medical services, the county is entitled to be reimbursed for such services from the parent of the child."

_____ _____

Guardian Signature Date

CHINA SPRING YOUTH CAMP/AURORA PINES GIRLS FACILITY

WILDERNESS/ORGANIZED SPORTS/ATHLETIC ACTIVITIES RELEASE FORM
PERMISSION RELEASE AND HOLD HARMLESS AGREEMENT

Child's Name: _____ Date: _____

I give permission for the minor child named above to participate in the activities of the Camp Sport/Athletic Program including, but not limited to: football, basketball, volleyball, baseball, yoga, swimming, etc. in and about the Camp areas and designated athletic/sports areas.

I give permission for the minor child named above to participate in the activities of the Camp's Wilderness Program including: hiking, general mountaineering survival techniques, swimming, backpacking, camping, ropes, cross-country skiing, snowshoeing, rafting, fishing, etc., in and about the wilderness areas and parks of Nevada and California.

I hereby agree to indemnify and hold harmless and blameless Douglas County, its officers, employees or agents from any and all liability from damages, loss or injuries, either to person or property, which the said minor may sustain while engaged in any activity conducted by or in connection with Douglas County, including, but not limited to, transportation.

I further state I am the parent, or have been appointed legal guardian by court order. I further state my child is physically able to participate in the activities set forth herein.

I further agree to reimburse or make good any loss or damage or costs the county may have to pay if any litigation arises on account of any claim made by said minor, or anyone in said minor's behalf, resulting directly or indirectly from said minor's participation in the county's activities.

I further agree in case of injury, illness the Camp staff shall have authority to act in the child's best interest.

In case of an emergency and no one can be reached at the above address or telephone number, please notify:

_____	_____
Name	Name
_____	_____
Telephone Number	Telephone Number
_____	_____
Relationship To Child	Relationship to Child
_____	_____
Signature of Parent / Legal Guardian	Date

ROPES CHALLENGE COURSE RELEASE OF LIABILITY

READ BEFORE SIGNING

Individuals who suffer from high blood pressure, heart disease, back problems, emotional instability, pregnancy or acrophobia should not go on high ropes without consulting their physician.

In consideration of being allowed to participate in any way in the China Spring Youth Camp/Aurora Pines Girls Facility Challenge Course Program, related events and activities, I, _____, the undersigned, acknowledge, appreciate and agree that:

1. The risk of injury from the activities involved in this program is significant, including the potential for permanent paralysis and death, and while particular rules, equipment, and personal discipline may reduce this risk, the risk of serious injury does exist; and
2. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and,
3. I willingly agree to comply with the stated and customary terms and conditions for participation. If, however, I observe any unusual significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately; and,
4. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE, INDEMNIFY AND HOLD HARMLESS China Spring Youth Camp/Aurora Pines Girls Facility, Douglas County, their officers, officials, agents and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and leasers of premises used to conduct the event "Releases", WITH RESPECT TO ANY AND ALL INJURY, DISABILITY, DEATH, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF THE RELEASEES OR OTHERWISE, to the fullest extent permitted by law; and,

5. I understand that the use of equipment furnished by China Spring Youth Camp/Aurora Pines Girls Facility constitutes an acceptance of the equipment. I agree to pay for any damage done to the equipment, property or property of others.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTANDING ITS TERMS. I UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

Participant's Signature	Age	Date Signed

FOR PARENTS/GUARDIANS OR PARTICIPANTS OF MINORITY AGE
(UNDER AGE 18 AT THE TIME OF REGISTRATION)

This is to certify I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release as provided above of all the Releases, and for myself, my heirs, assigns, and next of kin. I release and agree to indemnify and hold harmless the Releases from any and all liabilities incident to my minor child's involvement or participation in these programs as provided above, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES, to the fullest extent permitted by law.

Parent/Guardian Signature	Emergency Phone Number	Date Signed

Form G

CHINA SPRING YOUTH CAMP/AURORA PINES GIRLS FACILITY

C.H.O.I.C.E.S. PROGRAM MEDICAL INFORMATION FORM

(To be completed by parent/guardian. NOTE: All information is confidential)

1) Are there any physical limitations which would prevent full participation, including:

- ❑ Disabilities
- ❑ Diabetes
- ❑ Epilepsy/Seizures
- ❑ Heart Conditions
- ❑ Recent Injuries
- ❑ Recent Illness
- ❑ Allergies (Food)
- ❑ Allergies (Medication)
- ❑ Allergies (Insect, etc.)
- ❑ Asthma/Breathing Problems
- ❑ Back Pain
- ❑ Bedwetting/Incontinence
- ❑ Motion Sickness
- ❑ Urinary Tract Infections
- ❑ Menstrual Problems
- ❑ Venereal Disease (STD)
- ❑ Pregnancy (Current)
- ❑ Pregnancy (Recent)
- ❑ Tuberculosis
- ❑ Migraine Headaches
- ❑ Recent Sprains/Dislocations
- ❑ Recent Concussion/Head Injury
- ❑ Chronic Cough
- ❑ High Blood Pressure
- ❑ OTHER? _____

PLEASE EXPLAIN ANY ABOVE PROBLEM (Dates, Frequency, Severity, Extent of Limitation)

_____

_____

_____

2) Are there any psychological tendencies which we should be aware of (fear of heights or water, suicide attempts, drug/alcohol addiction, depression, etc.)?

_____

_____

_____

3) Please list all prescription drugs which the child is required to take, as well as the doctor who prescribed them, and the amount/frequency of administration. These will be held by Staff for the duration of the trip. PLEASE BE SURE TO SEND YOUR CHILD'S MEDICATION WITH THEM, IN A SUFFICIENT AMOUNT TO LAST THE TRIP.

_____

_____

_____

4) Wilderness Program staff carry a well-stocked first aid kit at all times, which contains the following over-the-counter medications. Please check those medications which you, as parent or legal guardian, give us permission to administer to your child in the event of illness:

- ❑ Acetaminophen (Tylenol)
- ❑ Ibuprofen (Advil, Midol)
- ❑ Diphenhydramine (Benadryl)
- ❑ Dramamine (Motion Sickness)
- ❑ Pepto-Bismol
- ❑ Rolaids/antacid
- ❑ Pseudoephedrine (Sudafed)
- ❑ Mylanta/laxative

Signature of parent/guardian _____ Date _____

5) The Wilderness Program staff has been trained in the administration of *EPINEPHRINE* (a prescription drug). It reverses the effects of severe life threatening systemic (whole body) allergic reactions to substances such as bee stings or food allergies. An individual's past history is often not a reliable indication of future reactions. Therefore, we request permission to administer *EPINEPHRINE* in the event your child has a life threatening allergic reaction while in our care.

I/We _____ give CAMP Wilderness Program Staff permission to administer

EPINEPHRINE to _____ in the event of a systemic allergic reaction.

PLEASE CONTACT US IF ANY INFORMATION CHANGES OR DEVELOPS

Form H

China Spring Youth Camp/Aurora Pines Girls Facility
COMMITMENT FACE SHEET

Juvenile's Name _____ Camp Commitment Date _____
Social Security Number _____ Court Case Number _____
Date of Birth _____ County _____
Age _____ Current Grade _____ Juvenile Probation Officer _____
Birthplace _____ JPO Phone Number _____
Religious Affiliation _____ Race _____
Hair _____ Height _____ Tattoos _____
Eyes _____ Weight _____ Scars _____

Guardian at Commitment _____ Date of Birth _____
Phone Numbers: Home _____ Work _____ Cell _____
Mailing Address _____ City _____ State _____ Zip _____
Physical Address _____ City _____ State _____ Zip _____
Employment _____ SSN _____

Biological Mother _____ Date of Birth _____
Phone Numbers Home _____ Work _____ Cell _____
Mailing Address _____ City _____ State _____ Zip _____
Physical Address _____ City _____ State _____ Zip _____
Employment _____ SSN _____

Biological Father _____ Date of Birth _____
Phone Numbers Home _____ Work _____ Cell _____
Mailing Address _____ City _____ State _____ Zip _____
Physical Address _____ City _____ State _____ Zip _____
Employment _____ SSN _____

Mother (Step/Adopted) _____ Date of Birth _____
Phone Numbers Home _____ Work _____ Cell _____
Mailing Address _____ City _____ State _____ Zip _____
Physical Address _____ City _____ State _____ Zip _____
Employment _____ SSN _____

Father (Step/Adopted) _____ Date of Birth _____
Phone Numbers Home _____ Work _____ Cell _____
Mailing Address _____ City _____ State _____ Zip _____
Physical Address _____ City _____ State _____ Zip _____
Employment _____ SSN _____

Siblings Brothers (age/name) _____ Sisters (age/name) _____

Financial Info

Income of Parent(s)
Monthly Gross _____
Child Support _____
State Assistance _____
Food Stamps _____
Disability _____

Expenses
House Payment/Rent _____
Medical Bills _____
Utilities _____
Additional Monthly Bills _____

Form I